VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 5, 2015

Ms. Janine Paradee,Manager
East Terrace Home
71 East Terrace
South Burlington, VT 05403-6145

Dear Ms. Paradee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 14, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

NOV 0 2 2015

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed by the Division of Licensing and Protection to investigate a complaint regarding Resident Care and Rights. The following regulatory violations were found.	R100		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R179	Please see attached plans of correction.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Residential Senior Manager — (X6) DATE: 10/29/15

R179 - R213 POC accepted mBoltonRN/PMC 11/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 1 home failed to provide annual trainings for direct care staff that included the 7 mandatory trainings designated in the Residential Care Home (RCH) Licensing Regulations, effective October 3, 2000. Findings include: Per review of the list of staff trainings provided in the last 12 months on 10/15/15, the list did not include the following State RCH mandated trainings: (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation: (5) Respectful and effective interaction with residents Based on the review of training for a sample of 5 direct care staff, the Manager confirmed that none of the five had participated in the above listed 2 mandated trainings, as they were not offered by the management. The Manager did state that the Agency had revised it's trainings and planned to provide the new trainings to all direct care staff in the near future.	R179		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced	R206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R206	Continued From page 2 by: Based on staff interview and record review, the home failed to report an allegation of resident abuse regarding 1 applicable resident of the home to Adult Protective Services (APS as required by 33 V.S.A.) (Resident #1) Findings include: During interview regarding an anonymous allegation of resident abuse received by the State Agency concerning Resident #1, the Agency Manager of the home confirmed that s/he failed to make a report to APS as required. The Manager stated that she had asked the reporter if they thought the incident that had occurred was reportable and the staff member stated 'no'. Thus, no further investigation into the allegation was completed.	R206		
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to conduct it's own investigation into allegations of resident abuse and/or unsafe care	R207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R207	Continued From page 3 provision regarding 2 applicable residents of the home. (Residents #1 and #2) Findings include: Per interview on 10/15/15 at 10:15 AM, the Agency Manager of the home confirmed that s/he had failed to conduct thorough investigations into 2 separate incidents involving alleged abuse of Resident #1 and potentially unsafe care provision for Resident #2 after receiving information on 2 separate occasions. The Agency Manager stated that s/he had spoken with the alleged perpetrator who denied any improper actions in either of the 2 incidents. The Manager confirmed during interview with the surveyor that s/he had not spoken with all potential witnesses who may have had information related to the incidents, however.	R207		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the home failed to assure that each resident was treated with consideration, respect and in full recognition of the resident's dignity for 1 applicable resident in the targeted sample. (Resident #1) Findings include: Per interview on 10/15/15, Resident #1 stated that staff member (A) did not treat him/her with respect and dignity at all times. The resident stated that this staff member's lack of regard for	R213		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0608	A. BUILDING: _____ B. WING _____	C 10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TERRACE HOME (RCH)	71 EAST TERRACE SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R213	Continued From page 4 their feelings made them feel bad and disrespected at times, and s/he gave a specific example of this treatment. The resident also stated that staff member (B) was loudly using profanity when speaking to another staff member and the resident was offended by this language. When the staff member was asked to stop speaking this way, s/he rudely told the resident to return to their room. During interview with the House Manager, s/he confirmed that staff member (A) had been counseled regarding their lack of respectful resident care at all times, previous to the most recent incidents.	R213		

HOWARD CENTER
Help is here.

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
103 South Main Street, Ladd hall
Waterbury, VT 054671-2306

October 29, 2015

Dear Ms. Cota:

Listed below are the plans of correction for each deficiency cited in the complaint investigation at East Terrace Group Home, 71 East Terrace RCH of Howard Center Developmental Services that took place on October 14, 2015.

R179 V. Resident Care and Home Services

5.11 Staff Services

1. All seven mandatory trainings identified in the Residential Care Home Licensing Regulations have been developed/updated and are currently in the process of being uploaded into our training database to allow staff to complete these trainings. To ensure that deficient practices do not recur the Residential Manager for East Terrace, Janine Paradee, will review all mandatory staff trainings on a monthly basis. All seven mandatory trainings identified in the Residential Care Home Licensing Regulations will be available in the training database and completed by all staff by December 31, 2015. Corrective action will be completed by December 31, 2015.

R206 V. Resident Care and Home Services

5.18 Reporting of Abuse, Neglect or Exploitation

1. During the interview regarding an anonymous allegation of resident abuse, Residential Senior Manager stated that she had asked the reporter if they felt the incident that had occurred was reportable to APS and the staff member stated 'No'. Residential Senior Manager asked the reporter if they believed the situation occurred out of malice toward the alleged victim and the reported stated 'no'. Residential Senior Manager confirmed with reporter that all residents were safe. After this interaction with the reporter the Residential Senior Manager followed- up with a meeting with the staff involved in the alleged incident. Residential Manager followed up with Resident #1 that was alleged to be involved in the situation to gather more information and ensure the resident felt safe in the residence. Resident #1 reported that they felt safe and did not recount the incident as reported by the initial reporter. To ensure that deficient practices do not recur East Terrace Senior Manager, has reviewed the guidelines for reporting abuse, neglect, and exploitation and future incidents will be reported to APS within the designated 48 hour timeframe. Corrective action has been completed.

R207 V. Resident Care and Home Services

5.18 Reporting of Abuse, Neglect or Exploitation

1. Upon receiving information from the reporter the Residential Senior Manager followed up with the alleged perpetrator to discuss the alleged situations. The alleged perpetrator provided additional facts that were not initially reported by the reporter. With the additional facts and the knowledge of staff friction and disagreement with each other the Residential Senior Manager did not file a report to APS. Residential Senior Manager advised Residential Manager to meet with Resident #1 and Resident #2 to gain more information on the alleged situations. At the forefront of all communication with Resident #1 and Resident #2 was ensuring resident safety and both residents reported feeling safe in their residence. Additional staff was not interviewed, as they were not present for the incident. Per Agency policy any additional or further investigation would be conducted by Human Resources if an APS report is made involving staff. To ensure that deficient practices do not recur all future incidents will be reported to APS within the designated 48 hour time frame and Human Resources contacted to conduct investigations as appropriate. Corrective action has been completed.

R213 VI. Residents' Rights

1. East Terrace Group Home Residential Instructor A and B will read the Resident Rights as outlined in the Residential Care Home Licensing Regulation sections 6.1 through 6.18. They will sign a training record indicating that they understand and will comply with the regulations. To ensure that deficient practices do not recur the Residential Manager for East Terrace, Janine Paradee, will review section VI. Residents' Rights, of the Residential Care Home Licensing Regulations, with East Terrace Group home Residential Instructors at the next Staff meeting. Residential Instructors will sign a training record indicating that they understand and comply with the entire Residents' Rights outlined in Section VI. Corrective action will be complete by November 4, 2015 for all Residential Instructors. All future trainings on Residents' Rights will occur yearly and upon hire into the position or anytime Residential Management deems it necessary. Corrective action will be completed by November 4, 2015.

Please feel free to contact me with any questions or comments.

Sincerely,

Christine Rainville
Senior Manager, East Terrace
Howard Center
102 South Winooski Ave
Burlington, VT 05401
(802) 488-6515
christiner@howardcenter.org